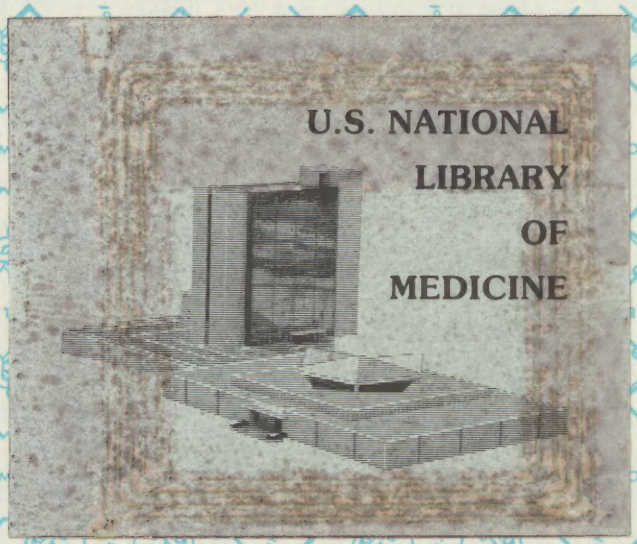

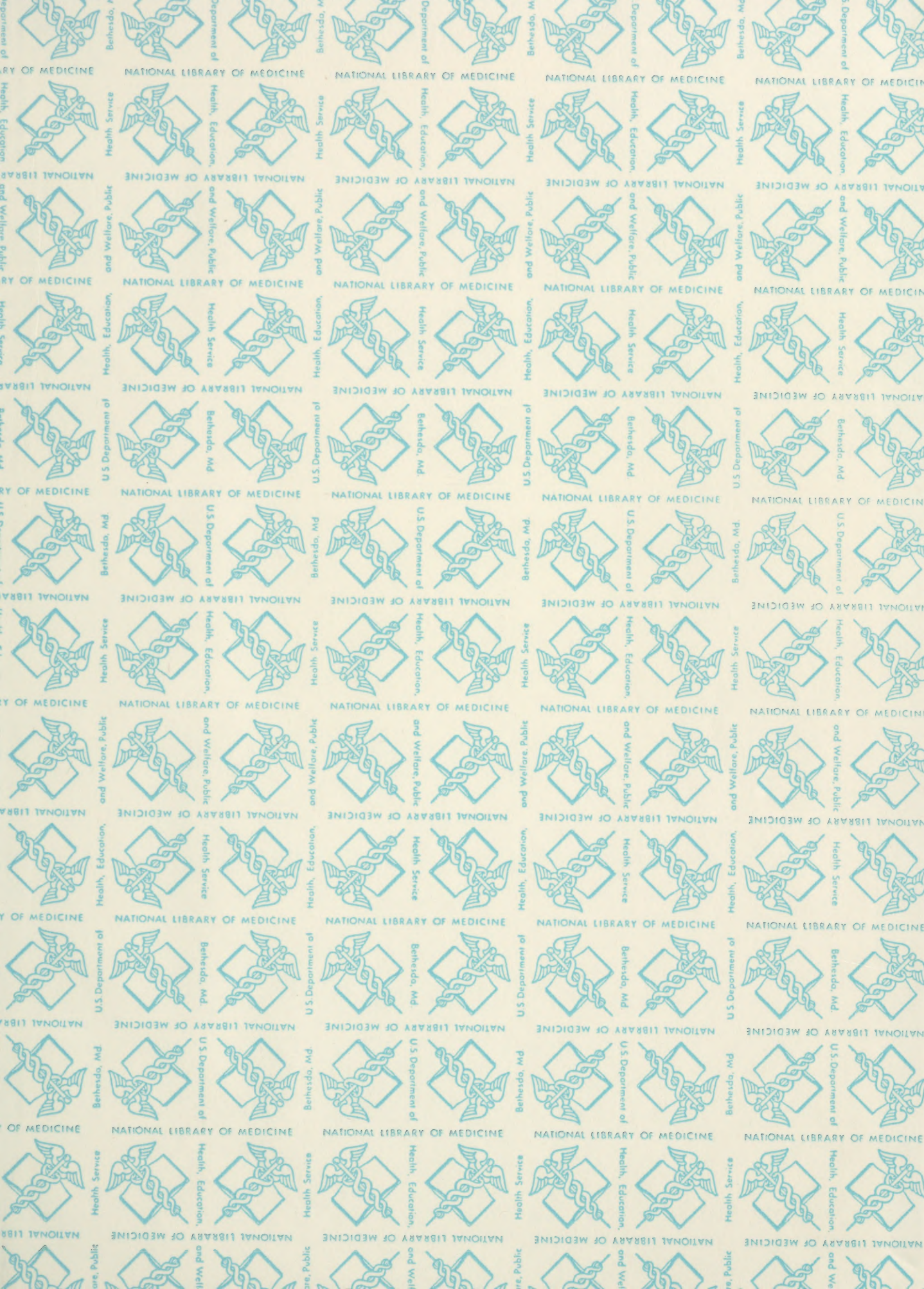
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REPORT
TO
THE GOVERNOR
AND THE
GENERAL ASSEMBLY
FROM THE

Connecticut.
COMMISSION ON THE CARE AND TREATMENT OF

THE CHRONICALLY ILL, AGED AND INFIRM

FEBRUARY 1, 1949

STATE OF CONNECTICUT

COMMISSION ON THE CARE AND TREATMENT OF THE CHRONICALLY ILL, AGED AND INFIRM

STATE CAPITOL, HARTFORD

Pursuant to Section 4196 of the General Statutes 1949, the Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm respectfully submits this biennial report to the Governor and General Assembly.

Joseph H. Howard, M.D.
Chairman

Stanley H. Osborn, M.D.
Commissioner
Department of Health

Mr. Robert J. Smith
Commissioner
Department of Welfare

Mrs. Elizabeth B. Lugg, Secretary
Rockville

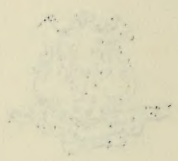
Mr. Herbert Crapo
Litchfield

Mrs. Eleanor T. Laggren
Hartford

James Raglan Miller, M.D.
Hartford

A. N. Creadick, M.D.
Medical Director

February 1, 1949



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In our previous report, we stipulated that solution of the problem of care and treatment of chronically ill, handicapped and aged persons required more effective medical service, and that remedial measures were of more importance than custodial care alone. We emphasized the fact that a central study unit to investigate the causes and relief of the commoner conditions predisposing to early deterioration and the handicaps of old age was required for an intelligent approach. Furthermore, this approach through improved medical care required doctors, nurses and technicians trained in a new field and not as yet available.

It might seem urgent to some to build big homes for custody and fill them at once. To do so would only prove that such a procedure was a temporary answer to the problem, that scientific progress might leave such structures in a few years as useless expenditure, that some other approach would have proven more economical and more humane.

Connecticut is the first state that has attempted to cope with the problem of chronic illness, infirmity and old age on a state-wide basis. Repeated surveys have been made showing the increasing load and offering suggestions to meet the most obvious needs.

Some states have attempted to create one central hospital and home only to have it crowded and require the building of others. Some states have attempted to solve the problem on a county basis and gradually create county homes. It is gratifying to us that New York and Illinois after prolonged study have adopted a procedure similar to our own suggestion although neither state has yet been able to put the program into effect.

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Healthy elderly people prefer to live in a manner to which they previously have been accustomed, in a congenial environment, with little regulation or supervision. When they have been able by thrift or insurance, or Social Security to preserve adequate means, their needs have been met by private arrangement with relatives or in homes, especially in the fraternal and religious institutions.

However, a large number of these healthy elderly people have no kin nor settlement; borderline or insufficient funds of their own, and have become recipients of Old Age Assistance. This was accorded by government on the theory that economic relief was all that was needed.

During the current inflation and housing shortage, this group have secured less favorable quarters and insufficient food. Lacking supervision, they have rapidly deteriorated and now create a pressing need on the Department of Welfare for "shelter" and nursing care.

These cases are a State responsibility and require some new facility for their care. In creating such housing, it is not simply custody but guidance in occupation, activity, stimulation, suitable nourishment and medical care that must be provided as well.

A large percentage of the people over 65 became State Wards because they are suffering from chronic diseases and handicapping injuries. Since 1943, in addition to Old Age Assistance, the State has been providing medical and hospital care. The present burden of Old Age Assistance includes annually over two and one-half millions of dollars of medical care. The Federal law and the State law have specified and preserved "free choice" of physician, and furthermore, deny benefits if the case is housed in a "public institution." The State-aided hospitals, strategically located throughout the State of Connecticut, are not classed as public institutions but have been too crowded to care for long term patients. Therefore, there grew up a quasi-hospital group, known as "convalescent homes" or "nursing homes" which are under the supervision of the State Department of Health, and after inspection and approval are issued licenses to operate hospitals for the care of chronic and convalescent cases only. In these hospitals or homes long term cases can find custody, shelter, food, nursing care and necessary medical care.

In the light of modern medical procedures, many of these cases could still be helped. There is a time gap between the discovery of new advances in science and their application to the general population. The term Rehabilitation has been given to this wide third phase of medical care.

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REHABILITATION

By far the most productive phase of our program is the training of old age recipients who are handicapped by disease or injury, to make use of their remaining faculties so that they may take care of themselves, be given some entertaining occupation and cease to require nursing and attendant care, thereby becoming less of an economic burden. This fascinating work has progressed most remarkably at the pilot study program in Rocky Hill but soon will be available in other centers following the guidance of the staff trained at the State Veterans' Hospital. It is amazing to see the difference in viewpoint that takes place when the patient finds that there are things he still can do and that he need no longer be bedfast as long as he can go through this program of training. Vocational and occupational training is possible for a younger group, but the older age group also get a tremendous improvement when they find there is something they can do to occupy their time.

Furthermore, because we believe that the activities of the care of the chronically ill, aged and infirm were more appropriately conducted near a medical center, we recommended that the general hospitals and municipal hospitals be encouraged to create within their walls, or nearby, suitable convalescent and chronic care homes where a moderate amount of nursing care and better medical attention could be afforded to those who needed it. It now becomes apparent that the pattern we originally subscribed to was correct and it also becomes important that we provide domiciliary care for those who have been rehabilitated and for those healthy ambulatory elderly people who have no homes and who require low cost housing, under moderate supervision, where their declining years can be profitably and happily spent.

The first sampling of welfare cases we received at Rocky Hill demonstrated that:

30% did not need expensive care in a nursing home but after rehabilitation could live in a private family or in a sheltered boarding home;

30% needed better medical care. These cases had been inadequately diagnosed or had additional disease that had not been recognized when last seen by their medical attendant; and

30% required considerable nursing care for the remainder of their lives. Therefore:

1. A certain number of cases in the nursing homes did not need such elaborate care.

2. The medical service in some of them could be improved.
3. The State must provide additional facilities for (a) the healthy, rehabilitated, elderly person, able to take care of himself and (b) for a certain residuum of helpless cases for which in our present state of knowledge, little more can be done.

Our Commission, four years ago, planned to develop units in conjunction with the State-aided hospitals to apply Rehabilitation to welfare patients. The first and most important step was to establish one central study unit as a pilot program to train doctors, nurses, physical therapists and administrative staff for work in this new field.

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PREVENTION

At the same time, it was conjectured that Rehabilitation involved the correction as far as is possible of the past failures of our medical facilities.

This has not always been the case. An analysis of our first hundred cases disclosed that accidents and willful personal errors had been a cause of disability as often as uncontrolled disease. For instance, the man who lost both feet from frostbite while hunting or the man who set his bedclothing afire and burned himself so severely that the scars incapacitated him. These and similar examples can be cited as proof that education is required in prevention, that industrial hazards must be controlled and measures must be taken to control the evils of alcoholism. Such preventive

measures fall properly within the realm of the Department of Health. We have stressed in our previous reports our support of the Health Department in facilitating annual physical inventory so that each individual can be advised of any error before it becomes incapacitating.

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HIDDEN LOAD

In all our planning, it must be remembered that there is a potential load hidden in the families of borderline income which load will add to the State's burden if periods of economic depression occur. Dr. William R. Willard of the Yale Department of Public Health recently made a survey and house to house spot check of one urban community and proved that a hidden load representing 123 cases per 1000 population was suffering from handicaps and chronic disease. Forty per cent of these were bed ridden and forty per cent were under forty years of age. Provision must be made for pay or part-pay medical and hospital care for these patients. This is an additional reason whereby units should be set up in or near general hospitals or operated similarly to general hospitals so that all economic levels of patients may be cared for.

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INFIRMARY CARE

At frequent intervals definitive medical treatment will be required for domiciliary cases who are subject to the same upper respiratory infections in the wintertime and other accidents which require acute medical care, and a facility must be created to serve these people either in the acute general hospital or in an infirmary as they need it. They can be returned to their nursing home or boarding home as soon as their condition has improved.

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TERMINAL CARE

With the limitations of our present medical knowledge and with the passage of time there will always be a certain number of patients who will require terminal care. These patients will have to be provided for in a ward or portion of the facility. It is not wise to try to create one single unit for hopeless patients at a distance from their families and isolated because under those circumstances it is impossible to secure medical and housekeeping staff without great expense, and their relatives and friends cannot visit patients at great distance.

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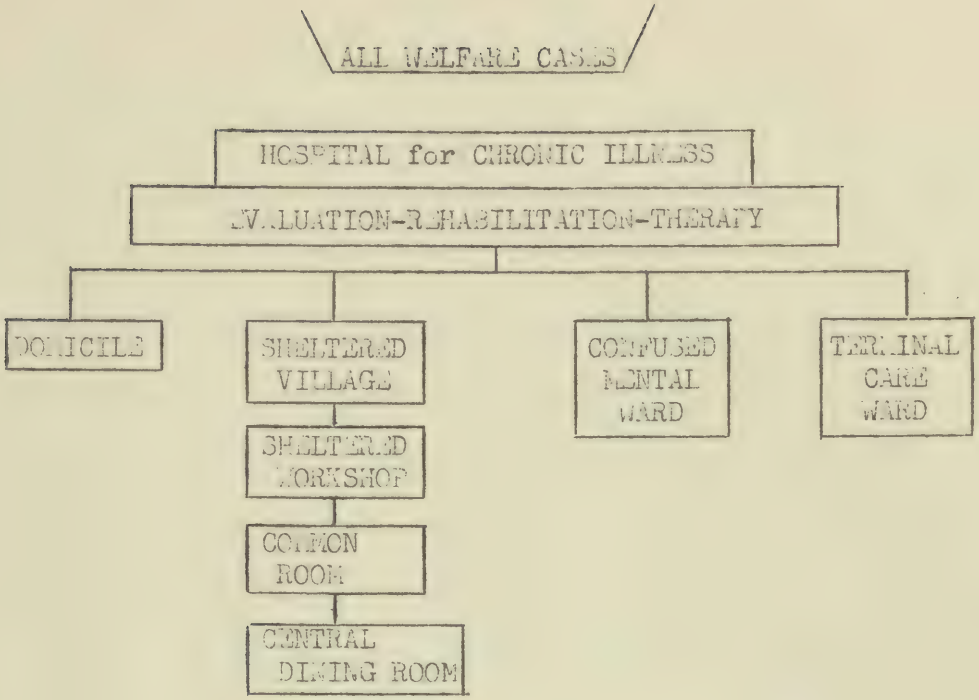
MENTAL "CONFUSION" CASES

Our attention has been repeatedly directed to the fact that a good many of these elderly people who are mildly confused have been committed to the insane asylums and that part of the load of patients in our mental institutions is made up of such cases. The temptation is strong to remove a large group of such cases at once to a new and separate plant. This is not advisable for several reasons. First, to commit such patients to the mental hospital without prior thorough medical study was wrong. Secondly, some of these patients may be truly psychotic and as such could best be treated in an institution for psychopathics. The correct medical procedure is to send these and all welfare cases to a good hospital facility for complete and thorough medical evaluation. Such a service cannot be rendered at home by an attending physician. Intricate tests must be made on delicate machines to distinguish mild confusion from true psychosis. The case that needs improved nourishment and some nursing care is probably only a "mental" problem in that forgetfulness is a burden, constant watchfulness has impaired the usefulness of some other healthy member of the family, or the daughter's housekeeping is not satisfactory to the older generation. Such a case belongs in the Welfare home and not in a mental hospital. As soon as the attending physicians decide the type of case, it should be sent to the appropriate facility.

In the last phase of our program, there must be a study of Geriatrics. That means studies into the causes and cure of all the deteriorating diseases that prematurely age and handicap man. The life expectancy of the whole population has been raised remarkably in the last decade by reason of the control of acute infectious diseases, the use of miracle drugs, the reduction in infant and maternal mortality. There is no reason to doubt that further improvement, even if less dramatic, in the survival rate may be accomplished.



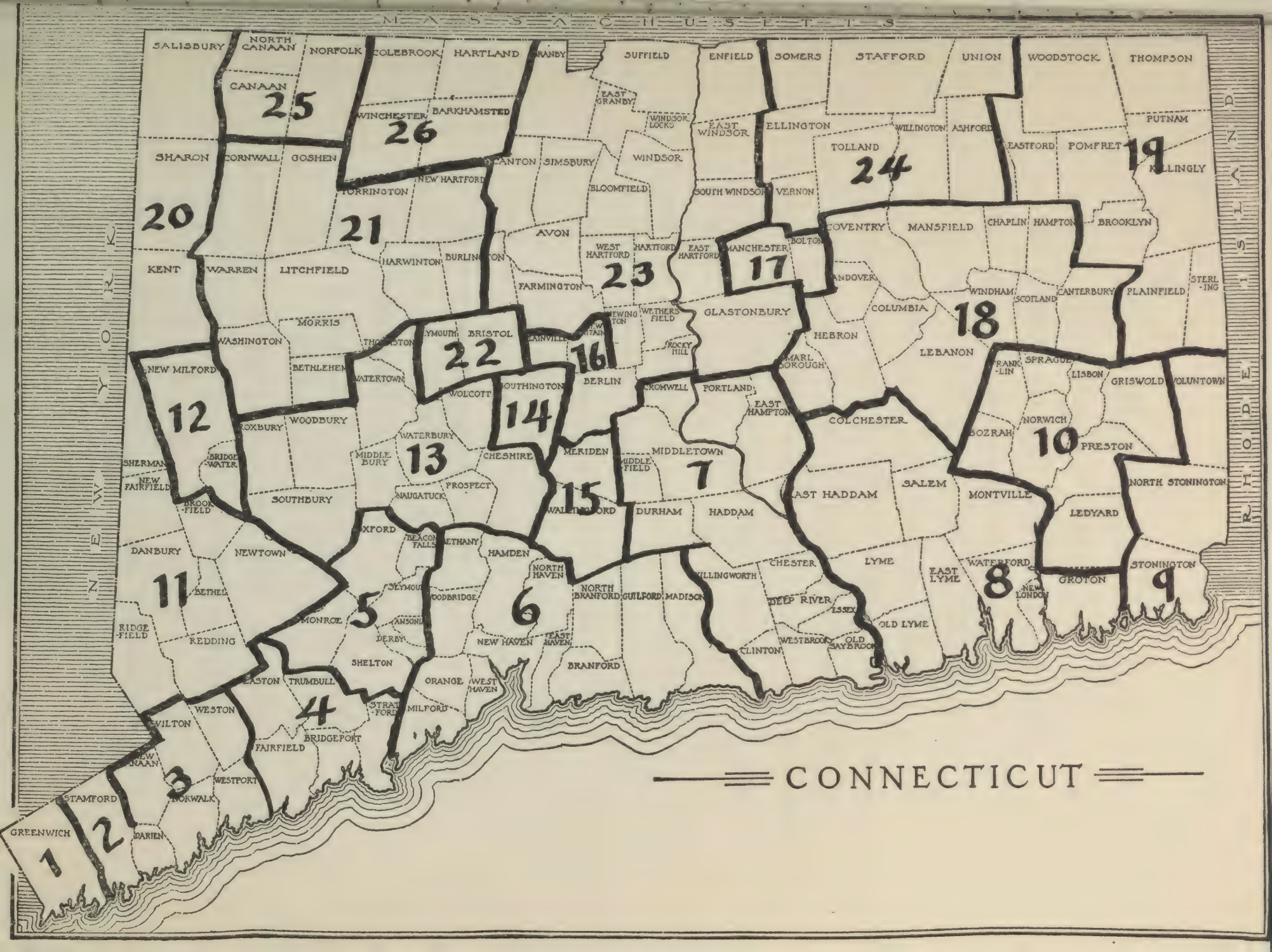
Therefore, all welfare cases should be channeled through the Hospital for Chronic Illness. There they should be evaluated and rehabilitated and treated. Thence, they should be referred to (1) domiciles, if they are able to take care of themselves; (2) to the sheltered village if they have no home or need mild supervision or guidance, where they might have a sheltered workshop, a common meeting room and central dining facility; (3) to a ward for confused mental cases requiring considerable nursing supervision and some medical treatment, or (4) to the ward where they received terminal care and their last days made as comfortable as was possible. All four of these units should be within easy reach of one another because from time to time there would be a re-check, a need for a shift in the population from a ward of one character to that of another with great facility and speed.

SURVEY - 1948

It is obvious that problems such as old age, chronic illness, custody, etc., know no political boundaries. Good social service recognizes that the best type of care be decentralized, be provided in surroundings to which the beneficiary is accustomed, in an atmosphere with which he is familiar and where he may find friends or associates of previous acquaintance. When such things as illness are involved he looks to the local medical center first or to some slightly more distant specialized institution well known as a center to meet his need. Therefore, it is obvious that in a small compact State like Connecticut, our plants should be in or near the health centers which are usually focussed around the area hospital. This is where he has been accustomed to look for medical advice and it is to those wards where he has been sent when injured or ill. It is in the area hospital where has been established the diagnostic facilities that may not be available in each doctor's office. It is here that the Tumor Clinics and Out Patient Departments have been developed. It is the focus where most of the health activities of the vicinity have been headed. Therefore, it seemed best to make a study of the State of Connecticut area by area as served by the medical center. The districts served by these medical centers are frequently regulated by the flow of traffic along good roads, are bounded by small geographical barriers that

frequently have no relation at all to political boundaries. There are quite a few of the small semi-rural towns in Connecticut that have no physician resident therein but these areas are served by men who go out from the immediately adjacent medical center and the population has become conscious of the fact. Furthermore, they drift naturally along trade channels to the nearest retail and shopping center. Very frequently we found that a small barrier like a stream or a hill bisects one 'Town' and the inhabitants of one side of the town drifted toward one medical center while those on the other side went in the opposite direction to another.

A map was prepared of the State of Connecticut showing the areas according to the habitual medical practice of the vicinity and conforming as near as possible to geographic and political boundaries, hoping a study of each of these districts would demonstrate the greatest need and the most efficient means of satisfying the same without disrupting the patients' familiar environment.


MASSACHUSETTS
NEW YORK
RHODE ISLAND
CONNECTICUT
SALISBURY
NORTH CANAAN
NORFOLK
COLEBROOK
HARTLAND
GRANBY
SUFFIELD
ENFIELD
SOMERS
STAFFORD
UNION
WOODSTOCK
THOMPSON
CANAAN
25
WINCHESTER
BARKHAMSTED
26
EAST GRANDY
WINDSOR LOCKS
EAST WINDSOR
ELLINGTON
WILLINGTON
ASHFORD
PUTNAM
TOLLAND
24
EASTFORD
POMFRET
19
KILLINGLY
SHARON
CORNWALL
GOSHEN
CANTON
SIMSBURY
WINDSOR
BLOOMFIELD
SOUTH WINDSOR
VERNON
TORRINGTON
NEW HARTFORD
20
21
AVON
COVENTRY
MANSFIELD
CHAPLIN
HAMPTON
BROOKLYN
WEST HARTFORD
HARTFORD
EAST HARTFORD
MANCHESTER
BOLTON
17
KENT
WARREN
LITCHFIELD
HARWINTON
BURLINGTON
23
ANDOVER
WINDHAM
SCOTLAND
CANTERBURY
PLAINFIELD
STERLING
FARMINGTON
NEWINGTON
WETHERSFIELD
GLASTONBURY
COLUMBIA
18
MORRIS
WASHINGTON
THOMASTON
PLYMOUTH
BRISTOL
22
FAIRVILLE
16
ROCKY HILL
HEBRON
LEBANON
NEW MILFORD
BETHLEHEM
WATERTOWN
WOLCOTT
SOUTHINGTON
BERLIN
MARLBOROUGH
FRANKLIN
SPRAGUE
LISBON
GRISWOLD
VOLUNTOWN
12
CROMWELL
PORTLAND
EAST HAMPTON
14
ROXBURY
WOODBURY
COLCHESTER
BOZRAH
NORWICH
10
PRESTON
WATERBURY
SHERMAN
BRIDGEWATER
MIDDLEBURY
13
CHESHIRE
MERIDEN
MIDDLEFIELD
MIDDLETOWN
7
NEW FAIRFIELD
BROOKFIELD
SOUTHBURY
NAUGATUCK
PROSPECT
15
WALLINGFORD
DURHAM
HADDAM
EAST HADDAM
SALEM
MONTVILLE
NORTH STONINGTON
LEDYARD
OXFORD
BEACON FALLS
BETHANY
HAMDEN
DANBURY
NEWTOWN
CHESTER
LYME
WATERFORD
STONINGTON
11
BETHEL
SEYMOUR
WOODBRIDGE
NORTH HAVEN
6
NORTH BRANFORD
GUILFORD
MADISON
KILLINGWORTH
EAST LYME
8
NEW LONDON
GROTON
9
DEEP RIVER
ESSEX
RIDGEFIELD
REDDING
MONROE
5
ANSONIA
DERBY
NEW HAVEN
EAST HAVEN
OLD LYME
CLINTON
WESTBROOK
OLD SAYBROOK
SHELTON
BRANFORD
EASTON
TRUMBULL
ORANGE
WEST HAVEN
4
STRATFORD
MILFORD
WESTON
WILTON
BRIDGEPORT
FAIRFIELD
NEW CANAAN
3
WESTPORT
NORWALK
STAMFORD
GREENWICH
1
2
DARIEN

The next important problem was to decide where the need is the greatest so that the immediate heavy load can be met and for this purpose a separate study has been made. We have contended that this unit should be associated with the local medical center and in the case of most areas of this State that means a local State-aided hospital. The contributory territory about these hospitals covers the State with very little overlapping. In the larger cities there are two or more State-aided hospitals and in those instances perhaps the unit should be impartially located and accessible to all. We prepared a chart of the State of Connecticut, divided into areas that normally drained their town cases and their welfare cases to the adjacent hospital. This shows twenty-six such areas. However, it would not be possible to organize such a number of chronic illness hospitals at once. Therefore, the most important to establish first would be in the areas that are now carrying the heaviest load of cases. So a second chart of the State was prepared showing where the number of cases was greatest and this conforms as is obvious to the centers of population because the numbers are significant in urban areas. This does not contend that there are not elderly people and chronic invalids in the rural communities, but that the numbers there are so small in comparison that they could be cared for in the larger area units, once the latter are established. Then, too, the problem of creating these chronic

hospital units in connection with the smaller hospitals would prove a burden to the area and to the hospital, but the cases from that area could be referred economically to the nearest larger unit. The resultant picture shows that the most urgent need will be found in Fairfield County, somewhere in the neighborhood of Bridgeport, in New Haven County, somewhere in the vicinity of New Haven and in Hartford County in the vicinity of Hartford.

ORDINARY OPERATING EXPENSES
OF THE COMMISSION - ACCOUNT
B-6010

Of the original appropriation of $20,000, the following expenditures up to January 31, 1949, have been made:

ADMINISTRATION:	
½ the Salary of the Medical Director 1 Personal Secretary Part Time Accounting and Clerical	11,097.22
FEES FOR OUTSIDE PROFESSIONAL SERVICES	671.25
Total Cost of Personnel to January 31, 1949	11,768.47
NO CAPITAL OUTLAY	
SUPPLIES - CONTRACTUAL SERVICES	290.50
TOTAL EXPENDITURES TO JANUARY 31, 1949	12,058.97

REPORT

OF

THE JOINT COMMISSIONS

STATE VETERANS' HOME AND HOSPITAL COMMISSION

COMMISSION ON THE CARE AND TREATMENT OF THE CHRONICALLY ILL, AGED AND INFIRM

Raymond F. Gates, Chairman

R. J. Smith, Secretary

HOSPITAL FOR CHRONIC ILLNESS

ROCKY HILL, CONNECTICUT

Operated Jointly By The

VETERANS' HOME AND HOSPITAL COMMISSION

and the

COMMISSION ON THE CARE AND TREATMENT OF

THE CHRONICALLY ILL, AGED AND INFIRM

Sec. 4197 Revised Statutes 1949

SEC. 4197. TEMPORARY HOSPITAL FACILITIES FOR THE CHRONICALLY ILL, AGED AND INFIRM AT VETERANS' HOME AND HOSPITAL. The commission on the care and treatment of the chronically ill, aged and infirm is authorized to establish temporarily at the veterans' home and hospital at Rocky Hill, upon the approval of the veterans' home and hospital commission, hospital facilities for the care and treatment of the chronically ill, aged and infirm. When so established and during the period maintained at the veterans' home and hospital such hospital facilities shall be under the joint government and control of said commissions. Such hospital facilities shall be removed, upon notice to the commission on the care and treatment of the chronically ill, aged and infirm by the veterans' home and hospital commission that the space occupied therefor is needed for the care of veterans.

The modern hospital, constructed by the State Veterans' Commission, when completed would contain 600 beds. Since some of those beds were currently unoccupied by Veterans, patients of the Commission on the Care and Treatment of the Chronically Ill were welcomed.

It would have taken at least two years to build a similar facility for chronic illness, and it would have cost a million and one-half to build it and equip it. What was desired was a study unit to see what long term diseases could be handled, how much rehabilitation could accomplish, to see what welfare patients needed and to investigate the causes and treatment of the conditions discovered.

Furthermore, it was obvious that doctors, nurses, physiotherapists, etc. had to be trained in this new field. Here was a facility already established whose occupants needed the same type of care as the welfare patients whom we desired to admit needed.

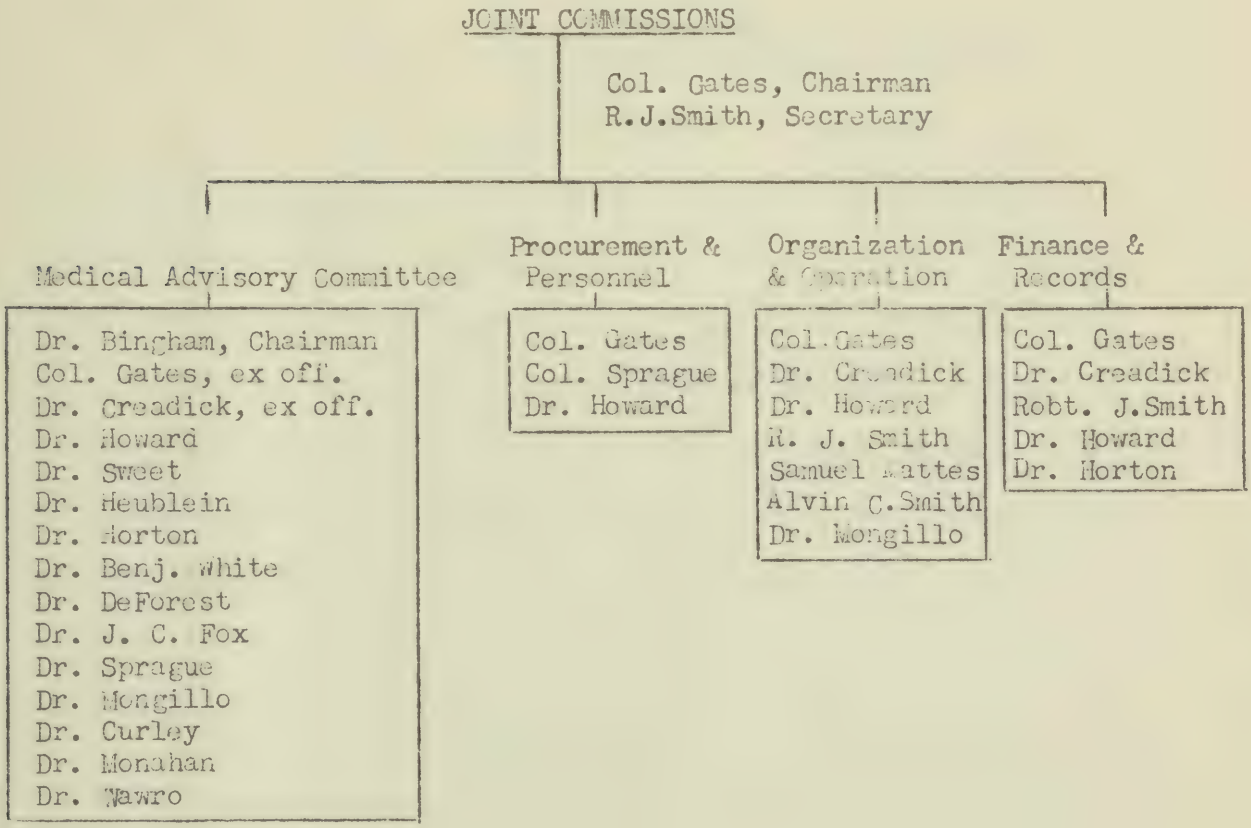
The General Assembly was to be congratulated on their intelligence and foresight in combining this experiment in a pilot study program with the distinct limitation in duration rather than the alternative of operating two identical units under separate agencies. Certain disadvantages were inherent in such a plan; for instance, combining two dissimilar agencies in a joint program, even of identical aim such as this, might cause friction. There has been no such difficulty apparent. Courteous cooperation has been the rule and we have heard no complaints. The hospital was understaffed and undermanned, but this was due to the general shortage of personnel. Positions had been set up for doctors, nurses technical assistants and an adequate number of staff personnel for 300 patients. One of our duties has proven to be aid in finding and interesting the necessary personnel to fill these appointments.

There was no deep X-ray therapy unit. Since the chronically ill patients were likely to require this treatment, it was just that the Commission on the Chronically Ill should purchase and install that equipment.

Any study that involved research in the causes and treatment of the diseases of the chronically ill would require an extensive chemical laboratory. The existing laboratory was limited and it was deemed a just charge against the joint fund that improvement of the laboratory should be made.

Social Service for the Veteran was provided for through the regular channels, the Veterans' Service, Auxiliary, Legion, V.F.W., etc. Welfare patients, brought in from all over the State, a study of whose background entered into the causes and cure of their disease, and placement for them when rehabilitated, required social service facilities which were not available. Therefore, it was deemed just that a Social Service Department should be set up by the Chronically Ill Commission.

Under the act the two commissions met July 9, 1947 and organized as a joint Commission. This Joint Commission and its operating sub-committees have met at frequent intervals. The cooperation of all involved has been excellent, the work of the institution has become well and favorably known and the results are apparent.



RULES AND REGULATIONS

Admission is restricted to male patients referred by welfare agencies. While it was understood that the patients required long term care, nevertheless, the medical director was authorized to restrict admission to those cases for whom some remedial service could be rendered and to exclude terminal care patients and boarding patients.

The Internal Administration remained with the Commandant.

The Veterans' Home Commission charged the Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm $5 per diem for each patient's routine board and care. In turn the State Department of Welfare reimbursed the Commission on Chronically Ill and collected a like charge from the appropriate agency responsible for the patient. Each Commission paid for special orthopedic appliances, prosthetic devices and hearing aids when prescribed for its own patients.

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MEDICAL STAFF

In a similar sized hospital to that which we are operating at Rocky Hill there would be at least thirty-five or forty full-time physicians of all grades living in the hospital and caring for the patients. There would be ninety or more nurses and all the ancillary services in like proportion. There are few general hospitals of this size that do not have at least two employees for every patient therein. In addition, there are many attending physicians in each specialty who come in at regular intervals and

go over the cases in their various fields to see if they can contribute any additional knowledge to the care of the individual patient. When the Committee chosen by Governor Baldwin made a survey of the Veterans' Hospital at the request of the Veterans' Hospital Commission, some time ago, an outline was set up of an ideal staff for this institution depending on the size and number of patients admitted. That report required the choosing of a number of physicians based on the number of patients in the hospital and suggested a rate of pay which should be given them. A like number of physicians and nurses as well as other helpers have simply not been available owing to the general shortage throughout the country of this type of personnel. Part of that difficulty is undoubtedly the rate of pay which the State is prepared to offer in contrast to that now currently paid by the Veterans' Administration, private industry and the other employers of physicians and nurses. We, at present, have on duty in the hospital nine doctors and thirty-eight nurses.

The rates of remuneration have been set by a Committee on the Study of Rates of Remuneration for medical services for all State Agencies.

When the two Commissions met and discussed the operations of this facility, it was determined that the nurses, orderlies, and ward services, common to all hospital patients would be provided by the Veterans' Home and Hospital Commission for which they were reimbursed at the per capita diem mentioned. Medical staff care was to rest with the Veterans' Home and Hospital Commission up to a

HOSPITAL

Commandant

Coordinator

Chief Medical Officer
Major Sweet

Executive Officer

ial Service
)

Pathologist
McLeod

Radiologist
Lieberson

Chief of Medicine
Fairlie

Chief of Surgery
( )

Chief of Physical Medicine
Covalt

Head Nurse
Werme

Senior Medical Officers

Pierce Peters James Lambert

Asst. Physical Medicine
( )

Asst.
Head Nurse
Sullivan

Assistant Physicians

Sherwood Harned

Resident
( )

Resident
( )

Resident
(Storer)

Resident
(Mancoll)

Resident
( )

Resident
( )

Resident
( )

Resident
( )

Residen
(

Assistant Resident
Caldarelli

capacity of 300 beds and when the admission of chronically ill patients added to that total the Chronically Ill Commission was to meet the charge for medical services beyond that point. Furthermore, when rehabilitation was emphasized and a new department of physical medicine was created, it was felt that that charge should properly rest against the new cooperative venture. So far as the patients are concerned, once they are admitted to the hospital, there is no distinction made. Any patient becomes a medical problem and is treated with that in mind and not any idea of the source from which he was derived. Furthermore, when a physician is employed or a nurse is employed in the institution there is no distinction made in anybody's mind as to who is paying for that particular individual, whether it is the Veterans' Commission or the Chronically Ill Commission. This understanding was mutually agreeable to the members of the two Commissions and nobody but the administering authorities, the Colonel Commandant and the Medical Director knows who is actually signing the payroll.

We have called attention to the fact that the major duty we have to perform at this central study unit is to train a suitable number of doctors and nurses and physiotherapists to undertake this type of work in other institutions around the state, and to that end, great emphasis is now being placed upon the resident program, whereby we are interesting doctors from Yale, from the Hartford Hospital and from other adjacent hospitals who are interested in continuing their training in a special field by securing their services here for varying periods of time, all of which contributes to their training and provides for us medical attention

for many of our patients. Pursuit of this program will attract a number of qualified men for periods of duty of six months to a year in this hospital who later will become available for practice in other hospitals and in communities around the State. The value of this program cannot be over-emphasized in planning to meet the complete need throughout Connecticut.

A large and competent attending staff of specialists, first including all those who were on duty with the Veterans' Home and Hospital Commission originally with additions as recommended by the Medical Advisory Committee and approved by the Joint Commissior represents a high standard of ability and prominence in the profession throughout the State. This staff is an "open" staff, open to any qualified member of the medical profession, preference being given to those who have their specialty board ratings in their particular specialty or who are members of the American Colleges or who have had the equivalent in years of practice. The services are then divided over the year so that everybody gets a tour of duty on the wards. These appointments are reviewed annually and made as of July 1st so that those who no longer desire to serve are dropped and those that are qualified are brought on. In this way, there is no likelihood of the hospital ever becoming "closed" or undue preference shown to one or another group. A list of the

attending physicians for the current year, divided according to their specialties, is attached.

In contrast to the provisions above mentioned, which are ideal for a hospital of this size, we return to a discussion of the current number of full-time employees in the medical field who are resident on the facility and who are at present employed in the care of the patients. To this group of men who are listed below unlimited credit should be given for their indefatigable interest in carrying a patient load which is unduly heavy. The risk taken in adding to this load is tremendous and it is scarcely within human possibility that such a small group can carry such a heavy load without some accident transpiring. It is of grave necessity that as fast as appropriate men can be found and attracted to take part in this program they should be added to the list. Either that or the facility must limit its admissions to meet the number of physicians now resident therein. If it is desirable to do good professional work, adequate staff must be provided or admissions will have to be restricted commensurate

with what men are able to accomplish. The same is true in the nursing field. We have a certain amount of turnover necessary by reason of the fact that some employees are taken ill or wish to change their field of activity or marry or retire, and replacements, while secured in a steady flow, have not succeeded in filling all the requirements for nurses that are immediately needed to prevent serious complications. Every device has been employed to try to lighten this load. One feature of rehabilitation has been encouraging groups of patients who have been rehabilitated until they are ambulatory to care for themselves and their fellow patients who are not so far advanced. Ancillary services like nurses-aides and auxiliary help have been explored and it is hoped that some of these will prove of assistance in the near future. As long as all the hospitals are suffering from a shortage of trained nurses and the numbers of people entering this professional field are as restricted in number as at present, great care will have to be exercised as to how hard they are worked.

ATTENDING STAFF

VETERANS' HOME AND HOSPITAL - ROCKY HILL, CONN.

ALLERGY

David L. Lieberman, M.D. - Middletown (and Chester)

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ANAESTHESIA

Ralph M. Tovell, M.D. - Chief of Anaesthesia - Hartford

Attending Anaesthetists

Charles M. Barbour, M.D. - Hartford
Richard F. Grant, M.D. - Cromwell
Carl S. Hellijas, M.D. - Hartford

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DERMATOLOGY

Neville Kirsch, M.D. - Chief of Dermatology - Hartford

Attending Dermatologists

Harry Bellach, M.D. New Britain
William B. Smith, M.D. - Hartford

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INTERNAL MEDICINE

Charles T. Bingham, M.D. - Chief of Medicine - Hartford

Attending Physicians

Timothy F. Brewer, M.D. - Hartford
Burdett J. Buck, M.D. - Hartford
Sidney H. Burness, M.D. - Hartford
Max Caplan, M.D. - Meriden
George H. Crawley, M.D. - Hartford
Gideon, DeForest, M.D. - New Haven
Allen F. Delevett, M.D. - Bridgeport
Ralph E. Durkee, Jr., M.D. - Hartford
F. Arthur Emmett, M.D. - Hartford
Augustus R. Felty, M.D. - Hartford
David Kydd, M.D. - New Haven
John C. Leonard, M.D. - Hartford
Edward Nichols, M.D. - Hartford

INTERNAL MEDICINE (CONT'D)

Attending Physicians

Gerald Pitegoff, M.D. - Hartford
Abraham M. Schaeffer, M.D. - Hartford
Wilson F. Smith, M.D. - Hartford
F. Erwin Tracey, M.D. - Middletown
Edward J. Turbert, M.D. - Hartford
Benjamin V. White, M.D. - Hartford
George A. Wulp, M.D. - Hartford

Associate Attending Physicians

William F. Donovan, M.D. - Hartford
Martin P. McCue, M.D. - Hartford
James S. Missett, M.D. - West Hartford
Philip F. Parshley, M.D. - Hartford
Charles E. Roh - Hartford
Paul H. Twaddle, M.D. - Hartford

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NEUROLOGY

James Fox, M.D. - Hartford

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NEURO-SURGERY

Attending Neuro-Surgeons

Bernard Brody, M.D. - New Haven

Associate Attending Neuro-Surgeons

Salo J. Silbermann, M.D. - Hartford

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OPHTHALMOLOGY

Henry L. Birge, M.D. - Chief of Ophthalmology - Hartford

Attending Ophthalmologists

Carl P. Bausch, M.D. - Hartford
Carl C. Chase, M.D. - Middletown
Louis D. Harris, M.D. - Hartford
William H. Joyce, M.D. - Middletown
Milton F. Little, M.D. - Hartford
J. L. M. O'Brien, M.D. - Bridgeport
Herbert M. Schwartz, M.D. - Hartford

OPHTHALMOLOGY (CONT'D)

Associate Attending Ophalmologists

Bernard A. Berman, M.D. - Waterbury
Leon W. Zimmerman, M.D. - Hartford

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ORTHOPEDICS

Robert M. Yergason, M.D. - Chief of Orthopedics - Hartford

Attending Orthopedic Surgeons

Edward H. Crosby, M.D. - Hartford
Charles W. Goff, M.D. - Hartford
Frank S. Jones, M.D. - Hartford

Associate Attending Orthopedic Surgeons

George G. Fox, M.D. - Meriden
Gerald S. Greene, M.D. - Hartford
Walter F. Jennings, M.D. - Hartford
J. Whitfield Larrabee, M.D. - Hartford
Anthony V. Nevulis, M.D. - New Britain
A. Lewis Shure, M.D. - New Haven
Edmond R. Zaglio, M.D. - Manchester

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OTOLARYNGOLOGY

Morris M. Mancoll, M.D. - Chief of Otolaryngology - Hartford

Attending Otolaryngologists

Lewis Chester, M.D. - Hartford
Timothy L. Curran, M.D. - Hartford
Walter L. Hogan, M.D. - Hartford
Wilbert E. McClellan, M.D. - Hartford
Pinckney W. Snelling, M.D. - Hartford
Charles A. Tucker, M.D. - Hartford
Edward J. Whalen, M.D. - Hartford

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PATHOLOGY

Christie E. McLeod, M.D. - Middletown

PSYCHIATRY

Attending Psychiatrists

Harold A. Bancroft, M.D. - Hartford
C. Charles Burlingame, M.D. - Hartford
Louis H. Gold, M.D. - Hartford
George A. Gosselin, M.D. - Hartford
Henry B. Moyle, M.D. - Hartford
Charles I. Solomon, M.D. - Meriden

Associate Attending Psychiatrists

William F. Prestley, M.D. - Hartford
Rebecca Z. Solomon, M.D. - Meriden

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ROENTGENOLOGY

Gilbert W. Heublein, M.D. - Chief of Roentgenology - Hartford

Attending Roentgenologists

Louis Bernstein, M.D. - Hartford
Elwood Godfrey, M.D. - Hartford
Stanley J. Lotyka, M.D. - New Britain
Charles C. Verstandig, M.D. - New Haven

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SURGERY

N. William Wawro, M.D. - Chief of Surgery - Hartford

Attending Surgeons

Edward S. Besser, M.D. - Manchester
William Curley, Jr., M.D. - Bridgeport
Harry S. Frank, M.D. - Middletown
William B. Kouwran, M.D. - New Haven
Louis C. LaBella, M.D. - Middletown
Benedict B. Landry, M.D. - Hartford
R. Starr Lampson, M.D. - Hartford
Phillip G. McLellan, M.D. - Hartford
David T. Monahan, M.D. - Bridgeport
Donald R. Morrison, M.D. - Hartford
John P. Reisman, M.D. - New Haven
Rocco J. Romaniello, M.D. - Hartford
Vincent J. Vinci, M.D. - Middletown
Welles A. Standish, M.D. - Hartford
Donald B. Wells, M.D. - Hartford
Edward P. White, M.D. - Hartford
Thacher W. Worthen, M.D. - Hartford

SURGERY (Continued)

Associate Attending Surgeons

Burwell Dodd, M.D. - Hartford
Thomas M. Feeney, M.D. - Hartford
George C. Finley, M.D. - Hartford
Samuel A. Jaffe, M.D. - Hartford
C. J. Lipkoff, M.D. - Milford
Christopher J. McCormack, M.D. - Hartford
Nicholas A. Mastronarde, M.D. - Hartford

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UROLOGY

Charles E. Jacobson, Jr., M.D. - Chief of Urology - Hartford

Attending Urologists

Harry C. Knight, M.D. - Middletown
Philip Cornwell, M.D. - Hartford
Robert Hepburn, M.D. - Hartford

The first units of the medical staff and physical medicine were obtained in February, 1948 and the first patient was admitted under the joint program on March 1, 1948. The case load in the hospital was so great and mounting so rapidly that it was deemed advisable to admit the patients of the Chronically Ill program slowly at first as beds were available and as personnel to care for the patients was obtained. A hundred welfare patients have been admitted so far and 64 are currently being cared for. In the beginning the Medical Director of the Chronically Ill program and the Medical Director of the Welfare Department made a hasty survey of the welfare patients in nursing homes in the vicinity of Hartford, some in New Haven and elsewhere. All the patients for whom some improvement might be expected were offered care at Rocky Hill. It must be borne in mind that there is no compulsion which can be put upon these patients. They and their attending physicians had to be convinced that new forms of therapy offered opportunity of benefit. In two or three instances certain convalescent homes were being closed or the State was abandoning the use of that particular home for State cases, in which event, the entire State population in those homes was accepted. For this reason, among the first cases were a certain number of severely ill terminal care patients. Actually up to the present time, 100 cases have been admitted under the joint program from out of the ranks of the chronically ill under welfare care. This will not lighten the load of the Commissioner of Welfare materially, but it has given us a sampling and a guide and proven what can be done and where our limitations may be.

PHYSICAL MEDICINE AND REHABILITATION

By vote of the Commissions, Dr. Howard A. Rusk, Professor of Physical Medicine at New York University and the dynamic leader in the subject of Rehabilitation, first with the Armed Forces and later with the Baruch Commission, was engaged as advisor for the operation of the plant at Rocky Hill and the development of the State-wide program for the care of the chronically ill, By mutual agreement, the most serious emphasis in the whole program was put upon organizing a model Department of Physical Medicine and Rehabilitation which others could see in operation, could imitate as far as they were able and which would train men and women in the fields involved so that they later would become available elsewhere in this state and in the nation to further this work. The patient load was tremendous. It made no difference whether they were patients of the Chronically Ill Commission or were Veterans. They all needed Rehabilitation. This has become especially apparent since the subject has been developed during and since World War II. It must never be lost sight of that while World War II furnished a number of patients which required this type of care, nevertheless in the civilian field during the same time, far greater numbers suffered chronic illness, accidents and disease who needed similar service.

An outline was prepared which shows what an ideal physical rehabilitation set-up would contain. Some of the illustrations herewith show the equipment which is necessary for the conduct of such a department. The total cost of installing the department and staffing it has been borne by the Joint Commission out of the funds allocated for this purpose by the last General Assembly. It has not been possible, even with the funds available to secure a complete personnel. In the first place, the number of institutions training people in this field is limited. We are one of the first outside of a few in the Armed Services and those set up by the Veterans' Administration. As our experience progressed, additional factors became apparent and the operation of the unit was gradually amplified.

MOTIVATION

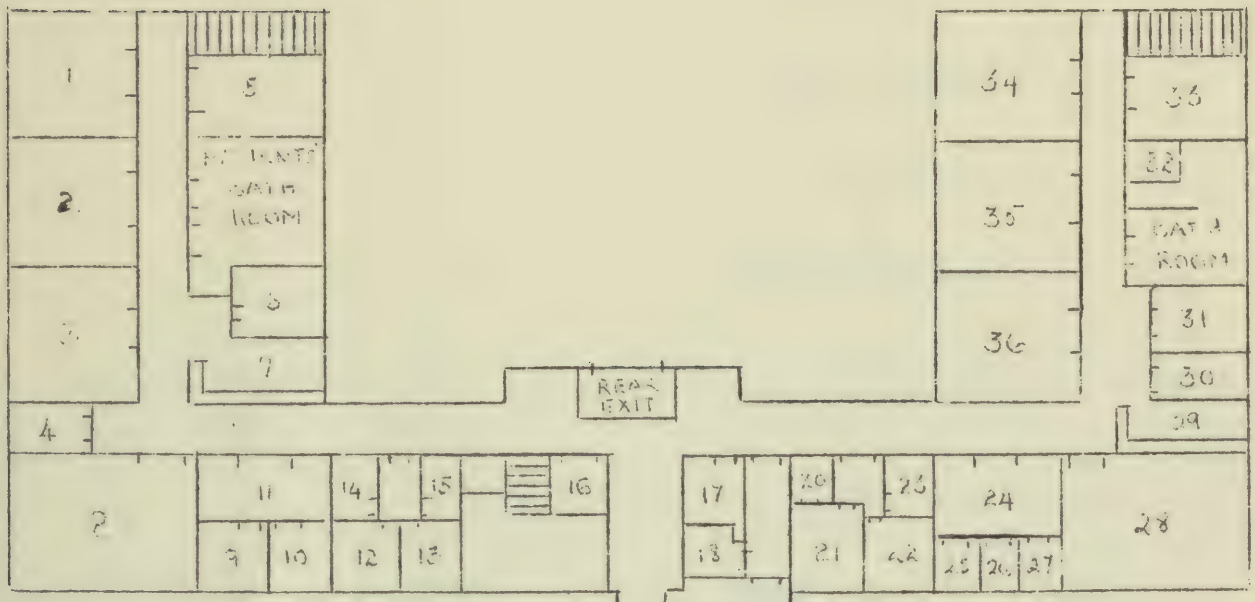
Attempts at Rehabilitation of those handicapped from disease and injury evidenced a need for upbuilding morale to help these patients face living under modern conditions, making the best use they can of what they have left. Results obtained can be measured not only in dollar value of economic savings these people can effect, but in the moral attitude of taking care of

themselves and releasing others from the necessity to care for them so that in the end they are really contributing to the economic usefulness of the community, proved the program can justify itself twice over on economic grounds. As to whether the numbers requiring this care will be reduced little evidence can be presented. The only thing that can be promised is that we will be able to decrease the financial burden on the State.

Committees from other localities, medical schools and various hospitals have visited our hospital and have seen the work we have been doing, attended our clinics and watched the men in Physical Medicine and Rehabilitation go through their exercises and operate their occupational therapy ventures. They have also seen them undergoing tests by the Vocational Division of Rehabilitation from the Department of Education so that those who may are given occupations to make them once more members of the productive community. Even the oldsters, out of the nursing home and out of the welfare department poorhouses have learned to occupy themselves in their hours of idleness with something like diversional therapy, so they no longer need to be indolent, but have learned creative crafts, if not actually become producers of wealth.

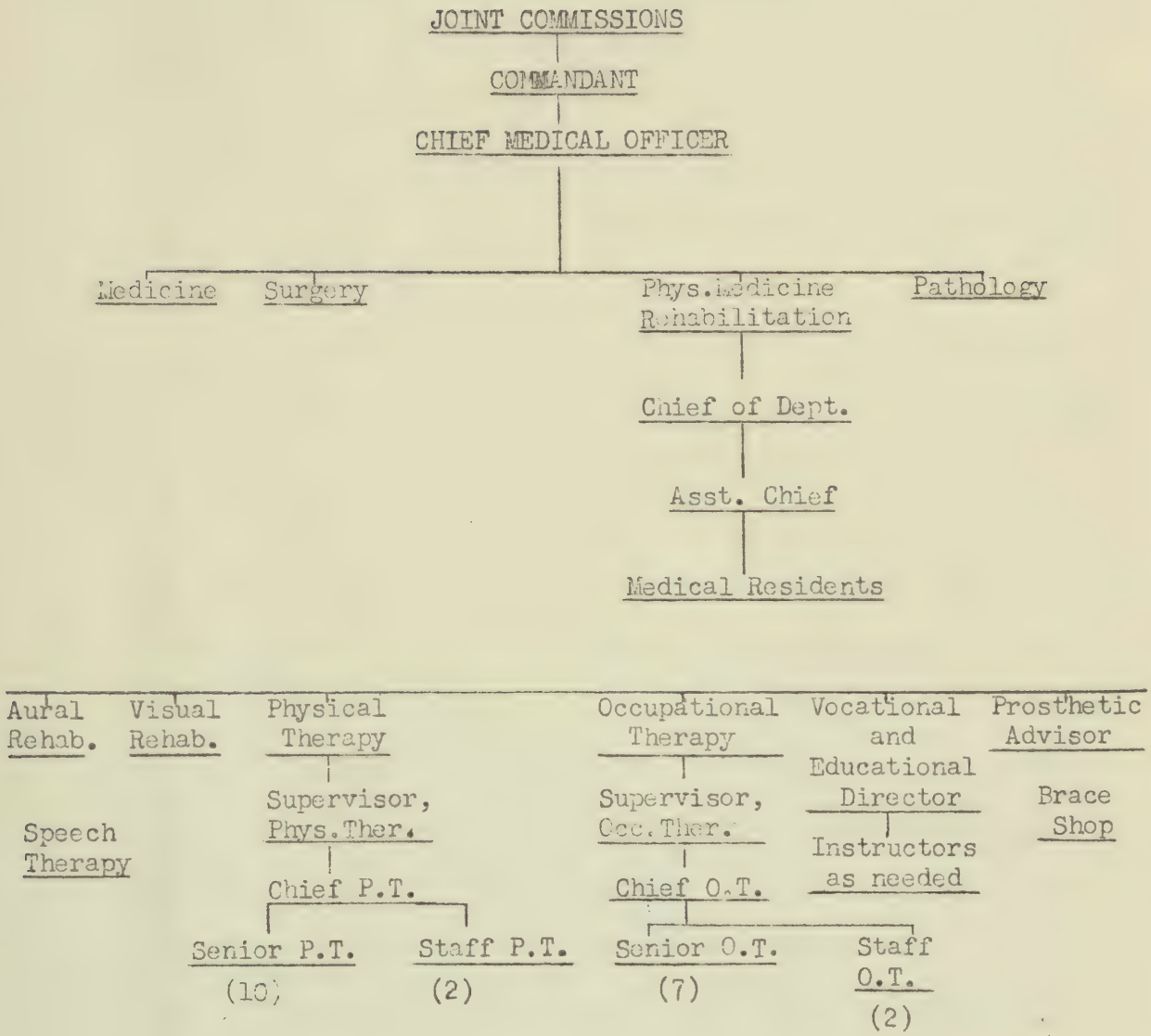
The first step involved the finding of a head for this program. The position of Chief of Physical Medicine and Rehabilitation was created and the appointment of Dr. Nila Kirkpatrick Covalt, formerly Associate Professor of Physical Medicine at New York University, was made. Following the recommendations of the Baruch Committee, Dr. Rusk and Dr. Covalt, a model floor plan was fitted out on the ground floor of the new wing of the hospital, thereby sacrificing thirty-six beds. A chart of the ideal personnel, the specifications for the positions and justifications for the same were prepared and a copy is attached. The major features of this program have gotten under way although all the positions have not yet been filled.

DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION
HOSPITAL FOR CHRONIC ILLNESS
ROCKY HILL, CONN.
FLOOR PLAN



1. Power Tools
2. Medium Crafts
3. Light Crafts
4. Photo Lab.
5. Print Shop
6. O.T. Prep Room
7. Office Space
8. Recreation, Clinics, Movies, Etc.
9 and 10. Classrooms
11. Library
12, 13, 14. Classrooms including:
   Speech Therapy
   VR and E Office
15. O.T. Office
16. Elevator
17. Staff Dressing Room
18. Elevator
19. Brace Shop
20. Doctor's Examining Room
21. Doctor's Office
22. Director of Voc. Ed.
23. Secretary
24. Staff Room
25. P.T. Office
26. Social Service Office
27. Recreation Office
28. Gymnasium
29. Office Space
30. Whirlpool
31. Hubbard Tub
32. PT. Class Treatment
33. PVD. Thermal Control
34. PT. Treatments
35. PT. Treatments
36. PT. Treatments

Scale: 1/32" 1'
Approx. 10,000 sq. ft. of work space, exclusive of corridors.


JOINT COMMISSIONS
COMMANDANT
CHIEF MEDICAL OFFICER
Medicine
Surgery
Phys. Medicine Rehabilitation
Pathology
Chief of Dept.
Asst. Chief
Medical Residents
Aural Rehab.
Visual Rehab.
Physical Therapy
Supervisor, Phys. Ther.
Chief P.T.
Senior P.T. (10)
Staff P.T. (2)
Occupational Therapy
Supervisor, Occ. Ther.
Chief O.T.
Senior O.T. (7)
Staff O.T. (2)
Vocational and Educational Director
Instructors as needed
Prosthetic Advisor
Brace Shop
Speech Therapy

The sum total expended on the establishment of the Department of Physical Therapy, structural changes and equipment amounted to $29,449.20. Salaries of personnel in physical medicine have amounted to $29,821.58 for 11 months and according to our plans, depending on the budget we receive, will cost for the coming year $65,000.

Under present patient load with the present personnel, we are now giving over 4,000 tests and treatments per month, which is a cost of $1.25 per patient per treatment.

The total cost to the State of the program at Rocky Hill has been $5.00 per patient for hospital care and the total expended of $200,000 per annum for the medical services, physical therapy prosthetic devices, etc.

From our short experience it would appear that it will cost nearly $1,000 per patient to effect the total rehabilitation program. The return on this investment is measured partly by the reduction in cost for the maintenance of the rehabilitated patients in a low cost domiciliary unit instead of an expensive nursing home.

In the case of the younger rehabilitated group, they will be returned to active production and will no longer be a charge on the town or state but rather in contributing to production will be an asset to the state.

One can readily see how rapidly this return will prove that the initial outlay was well invested.

COMMISSION ON CHRONIC ILLNESS
ACCOUNT C-6010-510
COSTS

Of the original appropriation of $600,000, the following expenditures up to January 31, 1949, have been made:

ADMINISTRATION: That portion of the operation of the Joint Program which required additional administrative help consists of:

- ½ the Salary of the Medical Director
- 1 Clerk III who admits and supervises C.I.A.I. patients
- 1 Secretary III for records and accounts
- Part-time accountants
- Part-time Coordinator of Therapeutic services

Total cost to January 31, 1949	14,684.15

MEDICAL STAFF:

- 1 Intern
- Medical staff - attending physicians

Total cost to January 31, 1949	51,868.00

DEPARTMENT OF PHYSICAL MEDICINE:

- 1 Chief of Physical Medicine
- 1 Clerk III
- 1 Stenographer III
- 2 Clerk-Typists II
- 8 Physiotherapists
- 6 Occupational Therapists
- Part-time speech therapist

Total cost to January 31, 1949	29,821.58
TOTAL COST OF PERSONNEL TO JANUARY 31, 1949	96,373.73
CAPITAL OUTLAY:	
Struct. Alter. for Instal. of X-Ray(10,992.60)	
Struct. Alter. for Physiotherapy (18,456.60) (10% withheld)	29,449.20
EQUIPMENT:	
Purchase of X-Ray machine	13,335.88
Purchase of Equipment for Physiotherapy Dept.	16,536.92
Purchase of Administration Office Equipment	1,194.89
TOTAL CAPITAL EXPENSES	60,516.89
SUPPLIES - CONTRACTUAL SERVICES	42,168.25
PAID FOR CARE OF PATIENTS' PROSTHETIC DEVICES,etc.	1,034.10
TOTAL EXPENDITURES TO JANUARY 31, 1949	200,092.97
Less receipts to date from Welfare Dept. for Patients' board	35,410.00
NET EXPENDITURES	164,682.97

CONCLUSIONS

As the possibilities for rehabilitation became more apparent and the field for work became wider, as the physicians on duty themselves became more experienced, the case load became heavier and the results became more remarkable.

The Medical Advisory Committee chosen in October, 1947, began to function February 1, 1948 and they presented reports to the Joint Commission August 1, 1948 and January 1, 1949. Since copies of those reports are available it is only necessary here to mention some of their conclusions and recommendations.

The length of stay of patient in the hospital has increased. This adds to our daily census, prevents admission in greater numbers and develops the following as reasons therefor.

a) Major surgery is now more frequently done and is of the type requiring longer hospitalization.

b) Physiotherapy, occupational therapy, psychotherapy, job training and the like, require a much longer stay.

c) Securing prosthetic devices requires not only the purchase of artificial limbs and braces measured to fit but requires previous conditioning of the stump and a period of training in the use of the new device. This, too, takes from three to six weeks.

d) Since the Veterans' Administration at Newington has been closed for non-service connected disabilities, Rocky Hill has received a larger number of cases of severe long-term illness.

Our hospital is so well built and so completely equipped that there are very few additional outlays for capital expense that will be needed as far as we can foresee at present.

The new hearing-aid program will require the construction of two sound-proof rooms for electronic testing.

Additional laboratory space referred to previously will cause some minor structural changes. Funds are in hand to meet these requirements. The most serious needs emphasized in the medical staff report and indicated in our remarks above are those of additional personnel:

Chief of Surgery

Residents (7)

Internes (8)

Medical Social Worker

Medical Record Librarian

Vocational and Educational Director

A Coordinator to supervise volunteers and service clubs in their activities and at the same time arrange recreational rewards for the patients.

In the Department of Physical Medicine, the most urgent need is likewise in personnel:

An Assistant Chief or Director

An Educator for Vocational and Educational Guidance

Additional Physiotherapists and Occupational Therapists

For the coming biennium three alternatives are offered:

The veterans can continue the program

The joint program can continue

The rehabilitation program can be removed to another institution.

The enthusiastic support of all doctors, social workers, veteran agencies and laymen who have seen the work in progress guarantees that no curtailment or abandoning of rehabilitation can be entertained. If the Chronic Care Commission is reduced so that they cannot staff and pay for the program, the cost will have to be added to the budget of the State Veterans' Home Commission. If the General Assembly prefers to have the Veterans' Home Commission continue a program at Rocky Hill and move the Chronic Care program elsewhere that means duplication of effort and doubling of costs. The only important factor is that the program cannot be strangled by blanket cuts in trained personnel for both commissions unless such a plan is coupled with a reduction in the numbers of patients cared for.

CHAPTER III

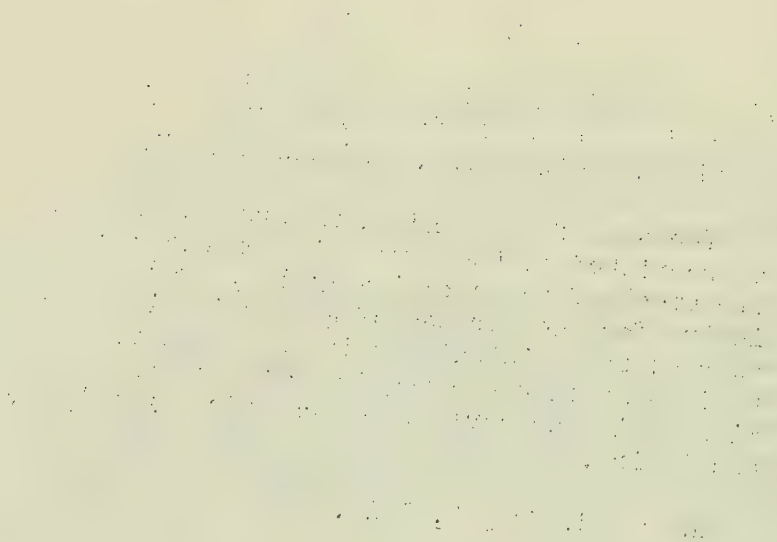
AID TO MUNICIPAL HOSPITALS

SPECIAL ACT 470 1947

AN ACT CONCERNING GRANTS IN AID TO MUNICIPAL HOSPITALS OR COUNTY INSTITUTIONS FOR CARE OF CHRONICALLY ILL, AGED AND INFIRM.

The sum of one hundred thousand dollars is appropriated to the commission on the care and treatment of the chronically ill, aged and infirm for the purpose of grants in aid to be awarded to municipal hospitals or county institutions meeting the requirements of said commission in the care of the chronically ill, aged and infirm.

Approved, July 9, 1947.



MUNICIPAL HOSPITALS

Grants in aid under this act were available to municipal or county hospitals who met the "requirements" of our Commission. Obviously the most desired requirement was additional beds for our State cases. Secondly, provisions should be available for the care of patients suffering from chronic disease. Among these provisions we considered rehabilitation most important. A complete plant would include some physiotherapy and occupational therapy as well as definitive medical and surgical care. There should be some domicile for the rehabilitated patient and some care for terminal cases.

Many factors would enter into the donation of these grants, particularly one institution might be lacking in one or more phases of the program and our purpose would be to aid each in completing these requirements. This aid might take one form in one case and another in the next. The prime interest on our part was to encourage the municipality to activate the care of their dependents by some energetic medical program to improve the present custodial function of these hospitals.

NEW BRITAIN MEMORIAL HOSPITAL

Ever since we realized that the study unit at Rocky Hill would be restricted to male patients, our Commission desired to set up similar facilities if such could be found for female patients. In January, 1948, at the suggestion of Dr. Lamoureux of the Department of Health, we visited the New Britain Memorial Hospital and found there an ideal nucleus for expansion. The City of New Britain had secured a charter and built a modern hospital for long-term care of chronic patients. The management was vested in a self perpetuating Board of Directors consisting of prominent business men, women and doctors who had operated the plant efficiently and economically. The nursing care had been contracted for with the Sisters of the Immaculate Conception, a nursing order of Polish nuns. The medical staff was elected annually and represented a good type of practitioner in the community. The present capacity of forty-five patients represented all economic levels and came from a wide distribution of territory. Directors, medical staff and nurses were anxious to increase the service, improve the remedial care, develop rehabilitation and provide service for a larger number of patients. Care of acute cases and definitive treatment of diseases was conducted in the nearby New Britain General Hospital. However, there was no facility for physiotherapy, no X-ray for follow up and for

emergency, incomplete laboratory for the routine tests and inadequate surgical equipment for the various emergencies that might arise. Many consultations between members of the Commission and the Board of Directors resulted in the preparation of plans for increasing the beds available to State Welfare cases and the appointment of a rehabilitation staff. Two sets of plans were prepared but each time bids were secured it was found impossible to build much for the sum this Commission could afford to allocate. It was finally determined by the Commission that $75,000 would be offered to the Board of the New Britain Memorial Hospital in return for 15 patient beds available for State cases for twenty years.

HILLSIDE HOSPITAL

Bridgeport

The Commission visited Bridgeport and were conducted through the municipally owned and operated home and hospital known as Hillside. This institution is clean and well run. It contains 300 healthy, ambulatory town needy cases and about 100 bed cases requiring nursing care. There is one physician in charge and a small attending staff on call for special services. We were favorably impressed because the Welfare Department, the medical attendant and the nursing staff were eager to perform better medical service for the occupants. It seemed to the Commission that much could be done by rehabilitation and occupational therapy.

Sometime later the medical profession got in touch with our Commission and explained that the services to Crippled Children and Adults, the Sheltered Workshop and similar agencies were likewise interested in improving their facilities. The school basement they were currently occupying was inadequate, poorly heated in winter, dangerous for their patients and the venture they had attempted elsewhere proved too expensive. We thought this was an opportunity to suggest a well-rounded program in which we might participate. In this case the building was in existence, was serving a wide territory, did not have a stigma, was in need of additional support which the municipality

alone should not be called on to provide for State cases. Our Commission proposed to the Mayor and Council of the City that if they would provide the space we would give a grant-in-aid to equip and staff a physical medical unit for rehabilitation and conduct therein care of all needy cases, State and City who would profit by such treatment. We have appropriated $25,000 for this purpose and subcommittees of both the City and the Commission are at the moment at work on the details of the plan and the perfecting of the agreement which will implement it.

CHAPTER IV

AID TO GENERAL HOSPITALS

SPECIAL ACT 446 . 1947

AN ACT CONCERNING GRANTS IN AID TO STATE-AIDED HOSPITALS FOR THE CARE OF CHRONICALLY ILL, AGED AND INFIRM.

The sum of two hundred thousand dollars is appropriated to the commission on the care and treatment of the chronically ill, aged and infirm for the purpose of grants in aid to be awarded to state-aided hospitals meeting the requirements of said commission in the care of the chronically ill, aged and infirm.

Approved, July 9, 1947.

We have indicated that there are twenty-six areas in the State centered about each area hospital as a health center.

REQUIREMENTS

A complete picture of chronic care in these areas would include a center in or near the acute hospital for the evaluation, rehabilitation and domiciliary care of chronic patients. Complete coverage of an area must include the cooperation of public and private agencies connected in any way with the various phases of this care. If mild mental confusion cases are to be cared for and proper nourishment given them to keep them from being committed to mental institutions adequate provision must be made. If medical care is needed to keep those in mature years from becoming incapacitated by crippling disease, active rehabilitation must be available. If a large number are without suitable domicile after rehabilitation, boarding homes must be created. It was the aim of our Commission by judicious grants in aid to the local State-aided hospitals to incorporate them into this program. One might have beds to spare but no means to employ adequate staff of physiotherapists, etc. Another might have plans for enlargement and want extra help to include chronic wings.

One universal difficulty stood in our way. Building costs were rising and the plans for additional construction were being abbreviated on all sides. It was hard for Boards of Directors who might be willing to include chronic beds to do so. Secondly costs of care in hospitals were mounting. Wards were closed by reason of a lack of personnel. Lastly officers were loathe to increase the load of State cases at rates now current for their care. The fund allocated to our Commission for grants in aid to State-aided hospitals might be used for added equipment, for added staff and for added operating expenses for this new type of medical care. One last obstacle still remained - there was a natural fear that these additional beds would soon be occupied with the type of long term occupant which the acute hospital dreads to have at the expense of acute cases needing restorative care. In other words there was inadequate housing for the domicile of recuperated chronic cases or prolonged nursing care. That this is a real problem has been indicated elsewhere in this report as our own experience in the State-operated study unit at Rocky Hill.

THE STAMFORD HOSPITAL

Our Commission was encouraged by the complete cooperation evidenced by the Town of Stamford and the Stamford Hospital. The intelligent approach was probably sparked by a study under the Council of Social Agencies there which included most of the agencies involved. The Town has a good town home, under efficient management. The Hospital Board is progressive. The Welfare agent had a far-sighted view of his burden of chronic cases in nursing homes and on Schofield Town Road. If the hospital could provide an area for care and treatment of the cases to establish what could be done, it is likely that the town can continue the care in cooperation with the Sheltered Workshop and other agencies and still house needy cases after their hospital stay. By purchasing some equipment, making a few structural alterations and securing personnel the hospital could care for thirty chronic cases on one floor and provide rehabilitation services. In return for a grant of $30,000 to meet the cost of the alterations, equipment and staff of physiotherapists the hospital would guarantee to make fifteen of the beds available to State cases. A form of agreement was drawn up approved by the Attorney General and signed by the Chairman of the Commission and the President of the Board.

NEW HAVEN

Your commission has had several conferences with the Director and members of the Board of the Grace-New Haven Community Hospital. The New Haven unit offered one floor of thirty beds for rehabilitation of chronic care patients. The hospital was not in a position to hire the additional medical staff and physiotherapists this care would require. A grant was voted on February 16, 1949 of $35,000 to initiate a program in the New Haven unit. This grant was to include personnel, structural changes, equipment and maintenance and twenty of the beds be assigned to State Cases.

Several other State-aided hospitals have consulted with the commission and are planning to participate in this program.

RECOMMENDATIONS

Who operates this program is of secondary importance to the preservation of the pattern and its thorough coordination and integration. The Commission found many private and public agencies interested in various phases of this work. The secular, religious and fraternal homes, the National Society for Crippled Children and Adults, the National Foundation for Infantile Paralysis, the Cancer Society, the Division of Rehabilitation in the State Department of Education, the various divisions of the State Department of Health and, of course all the divisions of the Department of Welfare are involved.

There is no implication of competition except in the enlisting of personnel. All are eager to cooperate in the care of the patients.

There is still a distinct need for the private convalescent home and the private boarding home. The town home or poor farm might be improved until it becomes a part of the program. The whole crux of the matter is to keep the patient from becoming static, fixed in any one place. Good care will require a coordinating, integrating supervising agency to encourage research, teach the newer techniques, suggest improvements, and charge each unit with responsibility in its field.

During the current session of the General Assembly the following program should be discussed:

(a) A redetermination of the standards of "need."
A reestimate of the amount needed for the remuneration of Old Age Assistance and the establishment of living quarters under supervision within the reach of Old Age Assistance recipients.

(b) A revision of that part of the social welfare laws dealing with social security and Old Age Assistance in order to permit residence in a state supported boarding home at some fixed charge against Old Age Assistance, but not consuming all of the patient's benefits.

(c) The improvement of the New Britain Memorial Hospital to create a unit for women comparable to the study unit for men at Rocky Hill.

(d) The development of complete units in other more populous centers, notably one in Fairfield County, near Bridgeport, and one in New Haven County, near New Haven.

(e) By far the most important and most urgent need is the request for "Sheltered Villages." In our budget request is included $2,000,000 for the purchase of land, construction and equipment of domiciles for healthy, ambulatory, rehabilitated, homeless, handicapped and aging men and women. Size, site, location and design are now under study by committees. We estimated that these "homes" can be constructed for $3,500 per bed.

OUR AIM:

TO ENABLE EVERYONE IN CONNECTICUT
TO ENJOY A HEALTHY, ACTIVE AND
PRODUCTIVE MATURITY BY
CONTROLLING CHRONIC DISEASE
AND BY RELIEVING OTHER PHYSICAL, MENTAL
AND SOCIAL PROBLEMS OF ADULT LIFE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